Quality is Our Bottom Line

Insurance Committee Public Hearing

Tuesday, February 7, 2017

Connecticut Association of Health Plans

(Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim & United)

Testimony in Opposition

to

Proposed S.B. No. 19 AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC CONDITION DURING CERTAIN ADVERSE DETERMINATION REVIEWS

Proposed S.B. No. 25 AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING THE ENTIRE ADVERSE DETERMINATION REVIEW AND EXTERNAL REVIEW PROCESSES

The Connecticut Association of Health Plans urges rejection of Senate Bills 19 and 25. Media headlines are dominated by the skyrocketing increase cost of pharmaceuticals from the Hepatitis C drug priced at its height at over $80,000 for a 30-day supply to EpiPens which went from $100 in 2007 to $608 for a two-pack today according to US News & World Report. Drugs known as "biologics" carry some of the heftiest price tags and can range into the hundreds of thousands of dollars.

This legislation, which requires insurance coverage for prescriptions while denials are under appeal, is dangerous not only in terms of just cost, but also in terms of quality. Similar bills have been considered several years in a row now and each has died with good cause.

From the cost perspective, one way that health plans bring value to consumers is by negotiating drug prices with pharmaceutical companies. Take Sovaldi, for example, which is the Hep C drug referenced above costing $84,000 dollars. Insurers might negotiate a much lower price for a competitor drug. If this bill were to pass and a doctor prescribed Sovaldi over the competitor drug covered by the health plan, the carrier would have to pay the price while the denial is under appeal. It's not even clear exactly how this requirement would work when an expedited appeal is turned around in 72 hours or less and the drug is dispensed in a 30-day supply. The math

doesn't always work. Further, appeals generally run 50/50 in favor of carriers. If a denial is upheld, is the consumer then left to cover the cost?

From a quality standpoint, what if a drug is considered experimental and potentially dangerous? The drug would be dispensed to the consumer and the carrier would have to pay for it until the appeal is decided. As a society, we have already experienced the dire consequence of the over prescribing of opioids. While previous versions of this legislation did exclude controlled substances, who's to say what the next class of drug is that will cause a public health crisis. Interestingly, its health plan medical directors that have been the most vocal against these types of proposals because they question the medical benefit of beginning a patient on a course of treatment, for what might only be one day, only to change it a day later.

The Insurance Committee has a number of related drug bills before it this session and you will undoubtedly note that much of the industry's testimony against them is the same. Employers and consumers are extremely price sensitive. Pharmacy is one of the single largest drivers of health insurance cost in Connecticut. On average, prices increase between 15% to 20% a year. The reasons are varied. The number of overall prescriptions issued has increased dramatically in recent years as new products come on line faster as a result of quicker FDA approval and, as always, consumer demand continues to escalate. Aggressive marketing of various pharmaceuticals also adds appreciable demand. Some drugs are prohibitively expensive, and yet they have no better clinical outcome than their less expensive alternative. Connecticut needs to keep drug costs under control and Senate Bills 19 and 25 undermine that ability.

As you consider these proposals and others of a like nature in the future, we hope you will take into account not only our testimony, but also the attached documents which provide much of the basis for our position. Drug prices can be exorbitant and fraud, while rare, does exist. As you can see from the Attorney General's recent press release, prior authorization of drugs provides an important consumer protection. While not always popular, health plans do provide a necessary check and balance on the system and their tools to do so need to be preserved for the benefit those insured.

Lastly, we ask that you appreciate the effect that these types of proposals will have on the fully-insured market in particular. More than 50% of Connecticut's market is self-insured - meaning their benefits are governed predominantly by federal law and wouldn't be affected by state specific legislation like this. Employers who self-insure tend to be larger companies and government organizations that can afford to take on their own claims risk. The fully insured market is dominated by small employers who pay a premium for insurers to take on the associated risk and, as such, they are those least able to afford the price increases of new mandates.

We respectfully urge the Committee reject SB 19 and SB 25.

Thank you for your consideration.

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Testimony

On behalf of the Connecticut Association of Health Plans, we respectfully urge that the Committee reject the majority of legislation on today's public hearing agenda. Things are changing rapidly at the federal level with respect to the Affordable Care Act (ACA), and until it's understood what the new landscape looks like, Connecticut needs to resist the temptation to adopt additional any new legislation. The Connecticut market is highly regulated with numerous consumer protections already in place. We are in a strong position. What the market needs now is stability and predictability, to the extent that's possible, and the best thing that the Connecticut legislature can do is to hit the "pause button" on new mandates and any substantive rewrites of insurance statute.

Taken as a whole, and individually, each bill on today's agenda raises significant concern for the industry. Many of the bills have been considered several times over the past and been dismissed - some because they're in conflict with the ACA, some because of their hefty fiscal notes and some because the underlying policy is ill advised. Several of the proposals before you are focused on issues that have already been addressed; and, while some may be well-intentioned, they will undoubtedly have unintended consequences that are enormously problematic.

Most of the bills before you this session have one trait in common - the negative impact they will have on health insurance premiums. Premiums, especially post-ACA, are simply a mirror we hold up to the cost of health care, and the reflection is not pretty - most of these bills fail in the most fundamental test: they all will result in significant increases in health care costs and, therefore, the premiums paid by individuals and businesses. Right now, that's a very bad idea.

Furthermore, we ask that you appreciate the effect that these types of proposals will have on the fully-insured market in particular. More than 50% of Connecticut's market is self-insured - meaning their benefits are governed predominantly by federal law and won't be affected by state specific legislation like this. Employers who self-insure tend to be larger companies or government organizations that can afford to take on their own claims risk. The fully insured market is dominated by **small employers who pay a premium for insurers to**

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take on the associated risk and, as such, they are those least able to afford the price increases of new mandates like these.

Lastly, the bills before you would undermine the strict timelines for action that are called for under the Affordable Care Act. Connecticut's Exchange is ***right now*** preparing their standard benefit plan designs and carriers are ***right now*** preparing their non-standard plan designs. Carriers must file their policies and associated rates with the Department of Insurance by mid-April. If any new mandates or restrictions on cost sharing are adopted in the meantime, the Exchange and the carriers will have to ***reopen*** the entire process allowing for adjustments to the AV calculator, re-submittal of all templates and the re-filing of all rates. Even the prospect of legislation like that being heard today, adds appreciably to market volatility.

No one knows exactly what is going to transpire at the federal level on the ACA, but we do know that predictability and stability is crucial to the health of the market here in Connecticut. Early rejection of these measures would provide health insurers with a welcome level of comfort during these times of uncertainty.

Attached to our testimony are some informational charts as well as a couple of articles of interest that may inform your understanding. In addition to the snapshot of our concerns provided under each bill heading below, we have also submitted detailed written testimony on a number of individual bills for your consideration.

Thank you for the opportunity to comment.

1. OPPOSE SB 19 AA REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC CONDITION DURING CERTAIN ADVERSE DETERMINATION REVIEWS. Requires coverage under "certain" adverse determination reviews for drugs other than schedule II or III used to treat a chronic condition. Does not apply to generic substitutions.

- Concept has died several years in a row. (SB34/2016, SB415/2015, SB186/2014, SB599/2013, SB18/2011)
- Fiscal notes indicate "potential" impact to state and municipalities because of self-insured status - meaning state employee plan wouldn't have to adhere to the policy. Impact is not indeterminant for employers.
- Pharmacy costs are rising 15-20% a year.
- Carriers need tools to combat the price gouging of pharmaceutical companies the stories of which dominate the headlines.
- Unclear how policy would work i.e. Sovaldi = $84,000 for 30-day supply.
- Appeal outcomes roughly run 50/50 in favor of the carriers. Would the member be required to reimburse the health plan if decision is found in favor of the carrier?
- Drug interactions? Experimental drugs? Extremely expensive drugs? Next public health crisis?
- Medical directors are most concerned. Patients start one course of treatment only to change a few days later.

- Step therapy concerns already addressed in Public Act 14-118 which bars health insurers from using step for more than 60 days. After 60 days, a provider call a regimen clinically ineffective and carrier must provide coverage. The act goes further and establishes an "override" provision that can be accessed at any point in the process and prescribes the conditions when an "override" must be granted.

2. OPPOSE SB 20 AAC THE FACTORS TO BE CONSIDERED BY THE INSURANCE DEPARTMENT IN A HEALTH INSURANCE PREMIUM RATE FILING REVIEW. Adds affordability as a factor in rate review.

- Rates are already highly regulated under state and federal law.
- Health carriers are subject to Medical Loss Ratio (MLR). Must spend 80% of premium dollar on medical and quality services in the small group market and 85% in the large group market or rebate consumers the difference.
- Department of Insurance undertakes annual approval process and looks at rates on basis of whether they are "excessive, inadequate or unfairly discriminatory."
- Rates must be sufficient to ensure health carrier solvency - the ultimate consumer protection.
- Small group rates can only be based on "an employer's geographical area and group size as well as the age, gender and family size make-up of the group."
- Health carriers are held to public notification requirements.
- Department maintains transparency website with e-alert capacity.
- Department of Insurance can hold public hearings.
- Connecticut's Exchange, Access Health CT, also undertakes its own review of rates.
- ACA lays out strict timelines for rate submittals and approvals which begin in April.
- Affordability is an important conversation, but it doesn't belong in the rate setting process.

3. OPPOSE SB 21 AAC HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED MEDICATIONS. Requires health plans to cover oral drugs at the same cost sharing level as their IV counterparts.

- Concept has died several years in a row (SB36/2016, SB7/2015, SB191/2014, HB6320/2013)
- Prior year fiscal note. SB 36 (2016) Fiscal Note
- Oral equivalents can cost excessively more than the IV versions.
- Pharmacy costs are rising 15-20% a year.
- Carriers need tools to combat the price gouging of pharmaceutical companies the stories of which dominate the headlines.

4. OPPOSE SB 22 AAC COST-SHARING FOR PRESCRIPTION DRUGS. Known as "cap the copay" legislation. Prohibits copays from being more than $100 for a 30-day supply and prohibits carriers from placing all drugs in a given class in the highest cost sharing tier.

- Capping copays will only result in increased premiums for consumers.
- Insurance Commissioner has already taken aggressive action and issued a bulletin on formularies last June requiring that all carriers file their prescription drug formularies with the department.

- Department is currently in the process of promulgating regulations for minimum standards for formularies.
- "Cap the Copay" is a national campaign largely funded by the pharmaceutical industry.
- Pharmacy costs are rising 15-20% a year.
- Carriers need tools to combat the price gouging of pharmaceutical companies the stories of which dominate the headlines.

5. OPPPOSE SB 23 AA REQUIRING SITE-NEUTRAL PAYMENTS FOR HEALTH CARE SERVICES. Requires that reimbursements be the same regardless of where service is rendered.

- Defeated in past years.
- Micromanages contract negotiations between sophisticated entities.
- All fees will rise as a result.
- Doesn't allow for recognition of different levels of facility capacity.

6. OPPPOSE SB 24 AA REDUCING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS. Reduces time frame for appeals from 72 hours to 48 hours.

- Concept has died several years in a row.
- Passage will have the unintended consequence of increasing the number of denials because most times the insurer is awaiting documentation from the member or provider in order to overturn the initial denial.

7. OPPOSE SB 25 AA REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING THE ENTIRE ADVERSE DETERMINATION REVIEW AND EXTERNAL REVIEW PROCESSES. Same as SB 19 above, but this proposal in even more expansive in that it appears NOT to be limited to certain chronic conditions and it applies to the "entire process."

- Concept died several years in a row. (SB34/2016, SB415/2015, SB186/2014, SB599/2013, SB18/2011)
- Fiscal notes indicate "potential" impact to state and municipalities due to self-insured status. (meaning state employee plan wouldn't have to adhere to the policy) it's indeterminant. ***Not indeterminant for employers.***
- Pharmacy costs are rising 15-20% a year.
- Carriers need tools to combat the price gouging of pharmaceutical companies the stories of which dominate the headlines.
- Unclear how policy would work i.e. Sovaldi = $84,000 for 30-day supply.
- Appeal outcomes roughly run 50/50 in favor of the carriers. Would the member be required to reimburse the health plan if decision is found in favor of the carrier?
- Drug interactions? Experimental drugs? Extremely expensive drugs? Next public health crisis?
- Medical directors are most concerned. Patients start one course only to change a few days later.

- Step therapy concerns already addressed in Public Act 14-118 which bars health insurers from using step for more than 60 days. After 60 days, a provider can call a regimen clinically ineffective and carrier must provide coverage. The act goes further and establishes an "override" provision that can be accessed at any point in the process and prescribes the conditions when an "override" must be granted.

8. OPPOSE SB 229 AA EXPANDING HEALTH INSURANCE COVERAGE FOR HEARING AIDS.

- Department of Insurance issued Bulletin HC-102 on June 15, 2015 which states that, "the Department has reviewed the age limit of 12 and under [in accordance with provisions of the ACA] and has determined hearing aids may be clinically effective for all ages, and is therefore requiring carriers to remove the age limits on hearing aid benefits for policies after January 1, 2016."
- Bill is unnecessary.

9. OPPOSE SB 426 AA PROTECTING PATIENTS FROM INAPPROPRIATE BILLING PRACTICES.

- Unclear intent.
- Public Act 15-146 (SB811) Hospital Roundtable legislation dealt with these issues.

10. OPPOSE SB 543 AAC INSURANCE COVERAGE FOR INPATIENT SUBSTANCE ABUSE TREATMENT PROGRAMS. Mandates at least 14 days of inpatient substance abuse treatment.

- Connecticut's carriers have been actively engaged in supporting efforts to address the state's opioid addiction crisis; working to craft legislation already passed and putting forth funding for last year's study by Yale. The industry is very concerned about the unintended consequences of mandated inpatient stays from both a quality of care perspective and also the associated cost. Need to assure that treatments have desired outcomes. Need to make sure we don't "clog" the system so that beds are available for those that need them. Very serious issue.

11. OPPOSE SB 546 AAC PARTICIPATING PROVIDER DIRECTORIES PROVIDED BY HEALTH CARRIERS AND PARTICIPATING PROVIDERS ACCEPTING NEW PATIENTS ON AN OUTPATIENT SERVICES BASIS. Requires carriers to keep an accurate list of participating providers accepting patients on an outpatient basis.

- Connecticut passed comprehensive legislation on this issue last year under Public Act 16-205. The act has only been in effect for one month. Need to allow the legislation time to work.
- Key to the accuracy of health plan networks is whether providers inform carriers of their status with respect to the individual carrier.

12. OPPOSE HB 5140 AAC REIMBURSEMENTS TO HEALTH CARE PROVIDERS FOR COVERED SERVICES PROVIDED FOR THE TREATMENT OF A SUBSTANCE USE DISORDER. Requires that insurers pay out-of-network providers directly for substance abuse treatment. Known as "assignment of benefit" legislation.

- Carriers have no direct relationship with out of network carriers for the basis to make payments. No access to tax identification numbers, addresses, etc.
- Creates a disincentive for providers to join health plan networks if they can get paid directly.
- Consumers are shielded from balance billing by providers when using in-network services. No such protection exists under out-of-network services.
- Passage of such requirements could exacerbate predatory behavior by unscrupulous out of state providers.
- Carriers have been actively engaged in the dialogue around the state's opioid crisis and would be happy to engage in any continuing conversations.

13. HB 5270 AA DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS. Reduces time frame for appeals from 72 hours to 24 hours as opposed to SB 24 which goes from 72 hours to 48 hours.

- Concept has died several years in a row.
- Passage will result in the unintended consequence of denials increasing because most times the insurer is awaiting documentation from the member or provider to make the decision.

14. OPPOSE HB 5441 AA REQUIRING HEALTH INSURANCE COVERAGE FOR LONG-TERM ADDICTION TREATMENT.

- Unclear intent.
- Connecticut's carriers have been actively engaged in supporting efforts to address the state's opioid addiction crisis; working to craft legislation already passed and putting forth funding for last year's study by Yale. Assuming the intent of HB 5441 is mandated inpatient treatment, the industry is very concerned about the unintended consequences of such stays from both a quality of care perspective and also the associated costs. Need to assure that treatments have desired outcomes. Need to make sure we don't "clog" the system so that beds are available for those that need them. Very serious issue.

15. OPPOSE HB 5962 AA PROHIBITING INSURERS AND OTHER ENTITIES FROM REQUIRING THAT INSUREDS DIAGNOSED WITH METASTATIC CANCER USE STEP THERAPY FOR ANY PRESCRIBED DRUG PRESCRIBED TO TREAT METASTATIC CANCER.

- Step therapy is a crucial tool that carriers use to support evidenced based medicine and to control costs. Treatment can vary vastly depending on where provided and by whom. Step therapy can assure that best practices are being put forth.
- The FDA actually sets forth the indications for many step therapy treatment regimens. At least one major carrier in CT has reported that they don't implement any step therapy provisions in this area that doesn't come directly from the FDA label.

- Legislature already dealt with concerns around step therapy with passage of Public Act 14-118 which bars health insurers from using step for more than 60 days. After 60 days, a provider can call a regimen clinically ineffective and carrier must provide coverage. The act goes further and establishes an "override" provision that can be accessed at any point in the process and prescribes the conditions when an "override" must be granted.
- Pharmacy costs are rising 15-20% a year.
- Carriers need tools to combat the price gouging of pharmaceutical companies the stories of which dominate the headlines.

16. OPPOSE HB 5963 AAC TREATMENT OR CARE PROVIDED BY RELIGIOUS NONMEDICAL PROVIDERS UNDER HEALTH INSURANCE POLICIES OR HEALTH BENEFIT PLANS. Allows carriers to include religious nonmedical providers as in-network providers.

- Legislation not necessary. Carriers could choose to choose to include such providers now.

17. HB 5968 AA REQUIRING HEALTH INSURANCE COVERAGE FOR FERTILITY PRESERVATION FOR INSUREDS DIAGNOSED WITH CANCER.

- Concept has died several years in a row.
- Constitutes a mandate under the ACA and as such the state would be required to pick up the costs.
- Excerpt from the OLR bill analysis on the same bill in 2015, HB 5500 "Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date."

20. OPPOSE HB 6431 AAC UTILIZATION REVIEWS. Requires that peer reviews of denials be done by in-state doctor. 21. HB 6433 AAC CLINICAL PEER REVIEW PERFORMED FOR PURPOSES OF A UTILIZATION REVIEW. Requires that initial denials be performed by a physician of the same specialty. 22. HB 6434 AA REQUIRING HEALTH CARRIERS TO INFORM THE COVERED PERSON WHOSE MATTER IS UNDER EXTERNAL REVIEW THAT THE CARRIER COMPENSATES THE INDEPENDENT REVIEW ORGANIZATION CONDUCTING THE REVIEW. Requires that consumers be informed that carriers pay for the cost of an external appeal review.

- Connecticut employs a nationally regarded external appeal model.
- The ACA imposes a number of requirements on the appeals process.
- Compliance with HB6433 would be nearly impossible and would have the unintended consequence of significantly delaying the process.

- To the extent these bills have a particular genesis, the Association would be pleased to work on the issue outside the context of legislation to address the concerns.

23. HB 6435 AA PROHIBITING HEALTH INSURERS AND OTHER ENTITIES FROM CHARGING DISABLED VETERANS FOR CERTAIN OUT-OF-POCKET EXPENSES.

- Elimination of cost sharing simply raises premiums.

24. OPPOSE HB 6436 AAC AN ARBITRATION PROCESS FOR SURPRISE BILLS AND BILLS FOR EMERGENCY SERVICES.

- Public Act 15-146 (SB811) Hospital Roundtable legislation dealt with these issues.

STATE OF CONNECTICUT
ATTORNEY GENERAL GEORGE JEPSEN

February 2, 2017

State Initiates False Claims Act Lawsuit against Fairfield County Doctor,nHusband over Alleged Compound Drug Prescribing Scheme

The state has initiated a lawsuit in Hartford Superior Court under the Connecticut False Claims Act alleging that a Fairfield County doctor and her husband, a University of Connecticut employee, engaged in a scheme designed to prescribe expensive medically unnecessary compounded medications to state employees enrolled in the state employee pharmacy benefit plan at a high cost to the state and its taxpayers, Attorney General George Jepsen said today.

The lawsuit stems from an investigation launched by the Office of the Connecticut Attorney General in 2014 after a request from State Comptroller Kevin Lembo, who administers the State of Connecticut Employee and Retiree Prescription Drug Plan.

"The allegations in this case involve a scheme to take advantage of the state's prescription drug benefit program by convincing state employees to try prescriptions for very expensive compounded drugs that are then prescribed by a doctor who never established a physician-patient relationship -- and who, in fact, never even met face-to-face with the patient," Attorney General Jepsen said. "This doctor utterly failed to adhere to even a minimal prudent standard of care and, therefore, this alleged conduct represents not only a serious abdication of her professional and ethical responsibilities but an egregious abuse of the prescription drug benefit plan and the taxpayer dollars that fund it. This investigation is ongoing, and my office will continue to work to hold accountable those who seek to defraud our taxpayer-funded healthcare programs."

Comptroller Kevin Lembo said, "I am grateful for Attorney General Jepsen and his team for today's action - part of a collaborative effort to protect the state plan from outrageous costs and protect employees from medically unnecessary and unregulated compound drugs. I immediately implemented a prior authorization measure that stopped a sudden and questionable surge in compound prescriptions, and then promptly referred the issue to the Office of the Attorney General for further investigation. The prior authorization requirement

has continued to successfully control compound drug costs, and now today's legal action holds individuals accountable for allegedly taking advantage of patients and the state's pharmacy plan. We must continue to respect decisions by doctors and patients, while also safely shielding against these kinds of abuses."

The state's prescription drug benefit plan provides prescription drug coverage to eligible state employees, retirees and their families. The plan's guidelines require that prescriptions covered under the plan be "medically necessary" as determined by a licensed practitioner "in accordance with generally accepted standards of medical practice."

The state's lawsuit alleges that Kwasi Gyambibi – an employee of the University of Connecticut in Stamford – and his wife, Dr. Kakra Gyambibi, met on several occasions with a sales representative from Advantage Medical and Pharmaceutical, LLC (Advantage) and received marketing materials concerning compounded pharmaceutical preparations created and dispensed by Advantage. They were also provided with Advantage prescription pads that contained common formulations for the compounded pharmaceuticals created and dispensed by Advantage, the state alleges. Advantage's business model uses commission-based marketing representatives to market its products, including compound drugs.

Compounded pharmaceuticals, unlike mass-produced, manufactured pharmaceuticals, are made based on a practitioner's prescription in which individual ingredients are mixed together in the exact strength and dosage prescribed by the provider. They are not approved by the federal Food and Drug Administration.

The state alleges that, from June 2014 to at least March 2015, Mr. Gyambibi sought out and approached his coworkers and convinced them to try compound pharmaceutical prescriptions offered by Advantage for their health ailments. The state alleges that Mr. Gyambibi assured his coworkers that the compounded drugs were effective at treating their condition and that his wife, a doctor, would write the prescriptions for them. The state alleges that, once a coworker agreed to try the compounded drug, Mr. Gyambibi provided Dr. Gyambibi with the coworker's personal and prescription benefit card information. Dr. Gyambibi then wrote the prescription without examining the patient, and the prescription was submitted to Advantage, the state alleges.

Dr. Gyambibi did not create or maintain any records documenting the care she provided to any patient for whom she prescribed a compounded pharmaceutical, and there is no documentation of an initial examination, plan of care, treatment note or any other medical record to support the prescriptions for the compound pharmaceuticals that she wrote, the state alleges.

At the time of the alleged conduct, Dr. Gyambibi was employed by a physician group that provided hospitalist services for several hospitals in Connecticut; hospitalists primarily provide medical care to hospitalized patients. Dr. Gyambibi never wrote a single prescription for a compound pharmaceutical product for any of her hospitalized patients, the state alleges.

Further, the state alleges that a large number of the individuals for whom Dr. Gyambibi prescribed compounded pharmaceuticals never used the prescriptions, yet they received numerous and unsolicited refills based on the initial prescription written by Dr. Gyambibi – each costing the state thousands of dollars per refill.

The state alleges that the scheme led to several hundred thousands of dollars in false claims to be submitted to the state pharmacy plan for payment.

The state's investigation into compounded pharmaceutical manufacturers and providers is ongoing.

Anyone with knowledge of suspected fraud or abuse in the public healthcare system is asked to contact the Attorney General's Antitrust and Government Program Fraud Department at 860-808-5040 or by email at ag.fraud@ct.gov; the Medicaid Fraud Control Unit in the Office of the Chief State's Attorney at 860-258-5986 or by email at conndcj@ct.gov; or the Department of Social Services fraud reporting hotline at 1-800-842-2155, online at www.ct.gov/dss/reportingfraud, or by email to providerfraud.dss@ct.gov.

For more information on efforts to address fraud in state programs, please visit www.fightfraud.ct.gov.

Legal Investigator Thomas Martin and Forensic Fraud Examiner Kevin Jeffko, working under the direction of Assistant Attorney General Michael Cole, chief of the Antitrust and Government Program Fraud Department, are assisting the Attorney General in this case. Former Assistant Attorney General Natasha Freismuth assisted on this case.

Please click here to view this complaint.

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Prescription Drug Spending For State Employees Runs Wild, Despite Cost-Saving Efforts

December 6, 2015

New state comptroller's statistics show that taxpayers funded nearly $332 million in prescriptions for the 200,000 participants in the state health benefits program.
(Handout / TNS)

Jon Lender

Prescription Drug Spending For State Employees Up 19 Percent, Despite Cost-Saving Efforts

Prescription drug costs under the state employees' health plan have run so wild that even a recently touted savings of $24 million a year — resulting from new restrictions on controversial compounded medicines — has been wiped out by an overall cost increase twice that large.

As soon as officials address one problem with prescription costs, another arises. It's like the arcade game Whac-A-Mole, in which a toy mole pops his head up, and as soon as you whack it down, another pops up from a different hole, and then another and another.

New state comptroller's statistics, obtained by Government Watch, show that taxpayers funded nearly $332 million in prescriptions for the 200,000

participants in the state health benefits program during the 12 months that ended June 30 — up about $53 million, or 18.8 percent, from the previous year's $279 million.

Moreover, the cost per participant jumped by an even higher percentage — 24.7 percent — because there were fewer state employees, retirees and family members participating in the program during the more recent year.

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Comptroller Kevin Lembo, the elected official in charge of running the state employees' health plan, has been using the Whac-A-Mole analogy for the past year in conversations about the problems with prescription drug costs. He did it again in a phone interview Friday.

"Something else always pops up. You always feel like you're chasing the next problem, and you're battling people sitting in rooms thinking of how to take advantage of programs designed to support the health and life of others," he said.

He attributed the latest $53 million escalation to a general skyrocketing of costs in the national pharmaceutical market, something that he said the state government has little influence over and that Congress needs to fix.

"The factors behind rising pharmacy costs include market consolidation, new pricing models and outright profiteering. Projections indicate no future relief as pharmacy costs are expected to continue to rise at an exorbitant rate in the coming years. Meanwhile, pharmaceutical companies are recording historic profits," Lembo said in written testimony he submitted this past week to the U.S. House Democratic Steering and Policy Committee. It's an all-Democrat panel co-chaired by U.S. Rep. Rosa DeLauro, who represents Connecticut's 3rd Congressional District.

Based on Congress' record of dealing with major health care issues, any quick solution is doubtful. But it appears that a Connecticut problem that reared its head in the past few years has been pretty much whacked.

That $24 million problem was compounded drugs — mixtures of medicines, typically produced by big, out-of-state compounding pharmacies, often in the form of topical creams for pain. Costs to Connecticut taxpayers for those medicines had exploded from $800,000 in 2012 to an estimated $24 million this year, with charges as much as $18,000 per patient for a 30-day supply.

Those medicines, not approved by the U.S. Food and Drug Administration, also were straining the prescription drug budgets of many states as well as the U.S. military and Department of Veterans Affairs as the compounding pharmacies exploited the lack of regulation.

In mid-May, Lembo imposed a "prior authorization" requirement for compounded medicines under which a prescribing doctor must demonstrate "medical necessity" before payment is approved by CVS/Caremark, the state's health benefits manager. A patient may appeal a denial.

Costs dropped from a peak of $3.1 million in April to $36,229 in July — and the average monthly savings on compounded drugs has been $2.2 million, according to a report to the comptroller by CVS/Caremark for the period from May 15 to Oct. 31.

The State Employees Bargaining Agent Coalition notified the state months ago that it was challenging the new policy on the grounds that it creates "too much interference in medical choices between a doctor and patient." But a Sept. 23 binding arbitration hearing has been postponed indefinitely while union representatives watch how the new procedure is working.

There have been only a handful of patient appeals so far, and the high-cost, out-of-state compounding pharmacies have been pretty much supplanted by

local, low-cost pharmacies, which have been mixing most of the compounded drugs still being used, Lembo said.

An investigation by the office of state Attorney General George Jepsen is "active and ongoing" into the recent spike in costs for compounded medicines, an office spokeswoman said Friday.

It's hard to trumpet the cost-savings for those compounded medicines — not in the context of a $53 million increase in the prescription costs for which state employees, retirees and their dependents are responsible for only minimal co-payments.

Prescription co-payments for a 30-day supply of medicine range from $5 to a maximum of $35. That top co-payment of $35 is for a "non-preferred brand-name drug" that hasn't been certified as medically necessary by a doctor; it drops to $20 with a physician's certification.

Lembo said in his congressional testimony that prices for name-brand medications, as well as for long-established generic drugs, are rising at an alarming rate.

He gave as an example a recent huge increase in the price of Daraprim, a medicine that has been used for 62 years to treat a potentially fatal parasitic infection. Turing Pharmaceuticals, a startup company headed by the former manager of a hedge fund, acquired the drug recently and raised the price from $13.50 per tablet to $750.

"We applaud the profit motive in our free market society as a mechanism to efficiently distribute resources and drive innovation, but excessive profits can cause significant harm when applied unbridled to essential and lifesaving medicines in an uncompetitive marketplace," Lembo said in his testimony. "High costs are pushing certain treatments out of reach for some."

He asked that Congress strengthen anti-trust laws "to limit consolidation in the pharmaceutical industry and ensure that adequate competition remains to drive competitive pricing," and to reduce a backlog in FDA approvals of generic drugs. He said the state employees' health plan spent $8 million in the past year for the name-brand drug Nexium "as a result of a significant delay in the release of a generic version of the drug."

Jon Lender is a reporter on The Courant's investigative desk, with a focus on government and politics. Contact him at jlender@courant.com, 860-241-6524, or c/o The Hartford Courant, 285 Broad St., Hartford, CT 06115 and find him on Twitter@jonlender

Health Spending in U.S. Topped $3 Trillion Last Year

By ROBERT PEAR
NYT DEC. 2, 2015

Excerpted....

..... Retail spending on prescription drugs increased sharply last year, rising 12.2 percent to $297.7 billion, the administration said in its report, published in the journal Health Affairs.

"This rapid increase, which was the highest rate since 2002, was in part due to the introduction of new drug treatments for hepatitis C, as well as of those used to treat cancer and multiple sclerosis," the administration said. The new treatments for hepatitis C, which are highly effective, accounted for $11.3 billion in new spending.

The numbers on retail drug spending do not include drugs administered at hospitals and doctors' offices, where patients receive many high-cost specialty drugs. Spending at those sites is embedded in other categories of spending and is not separately reported.

Many people with hepatitis receive care through Medicaid, the federal-state program for low-income people. "Medicaid prescription drug expenditures grew 24.3 percent in 2014, up from growth of 4.2 percent in 2013, as a result of increased enrollment and spending for drugs that treat hepatitis C," the administration reported.

Senate investigators said Tuesday that the makers of a breakthrough hepatitis drug, Sovaldi, had put profits ahead of patients in setting the initial price at $1,000 a pill, or $84,000 for a standard course of treatment.

Medicare prescription drug spending increased 16.9 percent last year, primarily because of the use of expensive new specialty drugs, including those for hepatitis, the report said.

....continued.

CT expands scrutiny of health plans
FEBRUARY 6, 2017
HBJ

Connecticut is taking a significant step to improve transparency of insurers' medical provider networks, a move doctors and regulators say is necessary as consumers face more complexities in where they can choose to receive care.

A new set of wide-ranging regulations give state regulators the power to determine whether or not a commercial health plan's network of medical providers offers consumers adequate access to health services.
The state Insurance Department also will assess for the first time ever the accuracy of insurers' published physician directories.

The rules address longstanding sources of friction between doctors and insurers. Doctors say there is a need for greater transparency over network adequacy, especially as health plans increasingly adopt "tiered" networks, which incentivize patients to visit certain medical providers over others.

Doctors have been skeptical of the tiered approach, arguing they don't always understand why an insurer places them in one tier instead of another (Connecticut's new law requires an explainer). They also argue that some tiers may not offer an adequate mix of specialists close to patients and who are also taking prompt appointments.

Insurers, meanwhile, have said splitting providers into tiers based on perceived value or other metrics has been an effective strategy to control healthcare costs by encouraging patients to seek care from higher-quality and/or lower-cost providers.

"It is important for policymakers to appreciate that broad access and affordability don't always go hand in hand and that high quality coverage can be afforded through structured provider networks," the Connecticut Association of Health Plans said in testimony on the new regulations last year.

Insurance Commissioner Katharine Wade said the new regulations, which took years to hash out, represent a compromise between insurers and doctors and align with standards issued in late 2015 by the National Association of Insurance Commissioners (NAIC), of which she is a member.

Connecticut is among the first states to adopt the bulk of the NAIC provisions.

Insurers in the state have opposed past legislative attempts to regulate network adequacy, but while the new rules increase state oversight, they likely won't do much — at least for now — to stop the spread of tiered networks.

"I think this is an area that needs increased focus," Wade said in a recent interview in her Hartford office. "We need to make sure that consumers fully understand the products they're buying and that the companies are providing networks that give people adequate access."

The effect of the regulations remains to be seen. Doctors say they are watching keenly, wanting to see improvement in directories and whether or not Wade determines if any in-state networks are insufficient.

"This, compared to what we had, is a really good additional step forward," said Dr. Jeff Gordon, president of the Connecticut State Medical Society and a practicing oncologist and hematologist with Hartford HealthCare in Waterford. "We're going to see how this actually works. We can talk in a year about the negatives."

Wade and her staff — which includes an examiner who specializes in network adequacy — are in the process of evaluating detailed reports submitted by nearly 50 health insurers.

Wade is now required to annually assess the adequacy of each plan network. It wasn't clear as of press time exactly how long the first round of decisions would take.

"We'll be looking at [the reports] and if there's adjustments that need to be made as a result of our review, then we'll be asking companies to do that," Wade said.

Wade said she will be paying close attention to behavioral health providers included in plans because Connecticut has a shortage of those practitioners, according to federal data.

The reports from insurers were originally due in mid-October, but the Insurance Department asked a number of carriers to submit additional information, which pushed the due date to Jan. 23.

Medical Society CEO Matt Katz said he is enthusiastic about the new rules overall and credits Wade's support as key to getting a bill through the legislature last year. But he's disappointed that the network reviews were not complete by the law's Jan. 1 effective date.

"We still don't know whether or not these plans have adequate networks and what needs to be adjusted as a result," Katz said. "That's a little disconcerting."

Directories

The new regulations aim to give insurance customers clearer information about their health plans by requiring doctor directories to be updated at least monthly. There will also be periodic audits.

The Insurance Department can enforce corrective actions and fines as high as $15,000 per violation.

Physician listings must include such information as speciality, office locations, group and facility affiliations, languages spoken and whether doctors are accepting new patients. Key for doctors who advocated for the rules is a provision that says insurers must indicate which doctors are in specific network tiers.

An outdated or inaccurate directory can cause headaches. And it can sometimes cause a patient to seek care from an out-of-network doctor, resulting in higher-than-expected charges, Katz said.

Network adequacy

Network adequacy is defined by the National Conference of State Legislatures as "a health plan's ability to deliver the benefits promised by providing reasonable access to a sufficient number of in-network primary care and specialty physicians, as well as all healthcare services included under the terms of the contract."

The federal government has crafted adequacy rules for Medicare Advantage and Obamacare plans. The regulations now taking effect in Connecticut are similar in many ways.

Under previous Connecticut law, insurers were required to attest they were accredited by one of two accrediting entities that monitor network adequacy, but the state played no role in that oversight.

Doctors weren't satisfied with that being the sole requirement, as accreditation involves more than just network adequacy. If a health plan failed the adequacy standards but did well in other areas, it would still pass, Katz said.

Wade said the accreditors — National Committee for Quality Assurance and URAC — have robust and regularly updated standards, but the new rules allow the state to check their work and make its own decision.
A spokesman for the Connecticut Association of Health Plans did not respond to requests for comment.

The law gives Wade wide latitude in how she reviews networks. There is no specific formula she's mandated to use, but her review could include such metrics as provider-patient ratios, geographic availability and wait times.

Doctors have pushed for specific metrics to be applied and Katz said his organization intends to pursue further legislation to make that happen.

Asked if she would be in favor of stricter rules, Wade said she would need to see a specific proposal first.

"The law just went on the books, so we need to give it a little bit of time to work," she said, adding that her office will listen to any complaints.

Gordon, the oncologist, said he hopes the new rules lead to noticeable improvements in the year ahead.

He said he has increasingly had trouble referring patients to other in-network doctors. Some might be far away, while others may not have openings for several weeks or more. That, to him, is inadequate.

Insurer directories can also come into play when referring patients. Since Gordon's staff uses them to help determine where to send patients, inaccuracies can cause delays and other issues, he said.

AWP

Then and Now: The cost of prescription drugs

Despite the introduction of new, and in many cases more innovative medical treatments, prescription drugs that have been around for years continue to get more and more expensive. And what about claims of innovation when the price of one drug can rise by an astounding 9,145 percent in only six months? 9,145 percent, really? This is just one example that we have highlighted below that shows while the drugs may have stayed the same -- their price tags skyrocketed.

Doxycycline in 2013
$20 per bottle

9,145% increase

Doxycycline in 2014
$1,849 per bottle

H.P. Acthar Gel in 2007
$700 per vial

4,471% increase

H.P. Acthar Gel in 2014
$32,000 per vial

U-500 in 2007
$220 per bottle

445% increase

U-500 in 2014
$1,200 per bottle

EpiPen in 2007
$56.64 per pen

222% increase

EpiPen in 2014
$184.35 per pen

Benicar in 2007
$2.25 per pill

164% increase

Benicar in 2014
$5.95 per pill

Gleevec in 2007
$118 per pill

158% increase

Gleevec in 2014
$306 per pill

Copaxone in 2008
$2,358.60
per 30 syringes

157% increase

Copaxone in 2014
$6,072.40
per 30 syringes

Sources
New York Times
New York Times
Bloomberg
New York Times
ProPublica
Forbes

RUNAWAY
AFFORDABLE PRICES FOR REAL CURES

MYTHBUSTERS: Rx PRICING EDITION

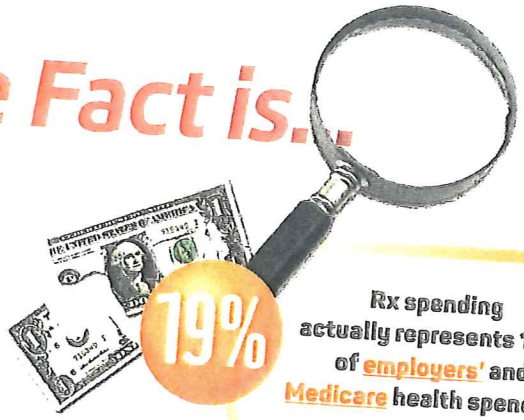
It's time to set the record straight on prescription drug prices and the scanty justifications for why they are so high. While the industry continues to minimize, shrug off, and ignore the problem, taxpayers, lawmakers, employers, doctors, and payers will keep asking questions. But the truth is we will never get to the bottom of this pricing problem as long as the industry remains shrouded in darkness with no transparency on how they set prices.

The Pharmaceutical Industry Wants You to Believe...

But the Fact is...

Prescription Drugs Represent Just 10% of the Health Care Dollar

✓ This misleading statistic ignores prescription drugs administered in a health care setting.



Rx spending actually represents 19% of employers' and Medicare health spending.

Research & Development (R&D) Costs Drive High Drug Prices

✓ R&D costs do not explain massive price hikes on brand name and generic drugs that have been around for decades.

✓ Nearly half of all R&D funding comes from the government, academic institutions, research hospitals, and charitable organizations.

✓ Drug companies spend 19 times more on marketing and advertising than they do on R&D.

9,000% increase on Doxycycline, from $20 per bottle in October 2013 to $1,850 by April 2014.
(GENERIC ANTIBIOTIC)

Competition Leads to Lower Prices

✓ Six-figure price tags are setting the floor, rather than the ceiling, for follow-on competitors.

✓ In 2012, all but one new cancer drugs were priced at $100k per year or more. By 2014, all but one were priced at $150k.

The top two insulin makers raised their prices in lockstep 13 times over 5 years.

Discounts and Rebates Make Drugs Affordable

✓ Even with discounts and rebates, Americans pay significantly higher prices than other advanced countries.

✓ Sovaldi was on the market for 14 months at the full price tag before any discounts were offered.

Even at a 50% discount, Sovaldi's price is still higher than its original developer had estimated.

For more information, please go to www.calhealthplans.org or www.runawayrx.org.

California Association of Health Plans

Quality is Our Bottom Line

Insurance Committee Public Hearing

Tuesday, February 7, 2017

Connecticut Association of Health Plans
(Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim & United)

Testimony in Opposition

to

Proposed S.B. No. 20 AN ACT CONCERNING THE FACTORS TO BE CONSIDERED BY THE INSURANCE DEPARTMENT IN A HEALTH INSURANCE PREMIUM RATE FILING REVIEW.

The Connecticut Association of Health Plans respectfully urges opposition to SB 20. Rate setting in Connecticut is already highly regulated in accordance with both state and federal law. Connecticut's Insurance Department (CID) undertakes a rigorous annual review of rates submitted by health insurers. In addition, CID imposes numerous requirements on the health plans in terms of their communication with their members about rates. The Department also maintains their own transparency website whereby consumers can sign up for e-alerts about rate filings and the Department has the ability to convene public hearings and, ultimately, to approve or deny health plan rate increases. Connecticut's health insurance Exchange, Access Health CT, also undertakes their own independent analysis of the rates submitted.

Having said all that, there are strict statutory provisions as well, both state and federal, as to the formulation of rates and there are strict timelines in terms of their submittal and approval. For example, in the small group market, rates may only be calculated on the basis of "an employer's geographical area, and group size, as well as the age, gender and family size make-up of the group." The Department reviews rates in terms of whether they are "excessive, inadequate or unfairly discriminatory." Plans are also subject to medical loss ratios (MLRs) whereby they are required to spend at least 80% of the premium dollar on direct medical care and quality improvement in the small group market and at least 85% in the large group market. If they don't, insurers are required to rebate the difference to consumers. Many of these provisions are further outlined in the attached FAQ prepared by the Department which we would encourage you to read at your convenience.

Solvency of insurance rates is, and should be, at the forefront of all consumer protections. Without the capacity to cover its claims, an insurance company can't exist and consumers are left without coverage. Connecticut has a highly competitive and healthy market with six major carriers competing for business. We are the envy of other states that may only have one or two major carriers offering coverage. Affordability and quality are the basis upon which Connecticut carriers compete with one another for customers and as such it is clearly front

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860.541.4923 | www.ctahp.com

and center in their rate setting process. However, you will note that the CID review specifically looks at "inadequate" rates in their review and that's to assure that health plans don't low-ball rates under the auspices of "affordability" to attract business.

Underwriting of insurance rates is a function of the underlying medical costs. While looking at the affordability of health insurance is an important conversation that needs to be had, it does not belong in the rate review process. In fact, we would argue that the focus of that conversation should be more on the underlying medical costs and if they are justified rather than on the insurance rates that are necessary to cover such costs.

We urge your rejection of SB 20.

Thank you for your consideration.

Frequently Asked Questions on Rate Filing, Rate Reviews and Approval of Health Insurance Rates in Connecticut

As the cost of health care continues to rise, many insurance companies and health maintenance organizations (HMOs) are seeking to increase premium rates.

Below are frequently asked questions about how health insurance rates are set, as well as some new initiatives to strengthen the rate review process and make it more transparent and understandable.

1. What causes health insurance rates to escalate?

Rates are driven in large part by medical care spending, which is growing because of many factors including increased use of health care services, new technologies, prescription drugs, an aging population, and unhealthy lifestyles. Rate changes occur when existing premiums are no longer sufficient to cover projected claims and administrative costs for that policy.

2. Are insurance companies required to seek approval from the Insurance Department before raising health insurance rates?

The Insurance Department is the only state agency which has been designated in law by the General Assembly to have authority over commercial insurance products. Connecticut has always had strong protections in place for rate review on health plans. Further protections have been added under the federal healthcare reform legislation.

Rate review varies by product as shown below:

Individual Health Plans:

Under its statutory authority, the Insurance Department reviews requests for increases on all individual health plans. By law, these health insurance rate increases must be approved by the Insurance Department before an insurance company may increase their prices to their customers.

Small Employer Plans (1 – 50 Employees):

The Insurance Department reviews health insurance rates used in calculating premiums for small employer plans. Small employer rates may be adjusted based on the specific employer's geographical area and group size, as well as the age, gender and family size make-up of the group.

Plans offered by HMOs must be filed for prior rate approval. Plans offered by indemnity insurance companies are reviewed to ensure rate increases are justified. Rates found to be unreasonable are reported to the U.S. Department of Health & Human Services (HHS).

Large Employer Plans (50+ Employees):

The Insurance Department reviews health insurance rates for HMO plans available to large employers (50+ employees). These rates may be modified by the insurance company to adjust for the actual claims experience for the specific employer's group plan.

3. Are there any plans that are not subject to rate review of the Connecticut Insurance Department?

Yes, employer groups that self-fund their plans are not subject to Insurance Department oversight because under law they are not insurance plans, but rather are regulated by the U.S. Departments of Labor, Health and Human Services and Treasury. Under self-funded plans, it is generally the employer and not the insurance company that funds and pays the claims. In that instance, an insurance company is often used only as a third party administrator paying claims under the direction of the employer.

Also, insured plans written outside the State of Connecticut are not under the Connecticut Insurance Department's rate authority.

4. Does the Connecticut Insurance Department approve the amount that employees or retirees are required to contribute to their health insurance premium by their employer?

No, employee contributions are set at the discretion of the employer and are not subject to approval or review by the Department.

5. What process does the Insurance Department use when reviewing requests from insurance companies for a rate increase?

Health rate filings are submitted electronically to the Insurance Department. In order to evaluate the merits of this request, the Insurance Department requires detailed information about the prior premium and claims history for that policy form and the projected medical claim trends anticipated by the company for the upcoming renewal period.

The Insurance Department's Actuarial staff then thoroughly reviews this information to verify the actuarial assumptions presented in the rate filing, and when necessary requests additional data to substantiate the information presented. If the Department's Actuarial staff does not agree with an actuarial assumption presented by the insurance company,

the Insurance Department will require the insurance company to revise the filing to reflect the Department's assumptions, resulting in a lower rate request.

6. Are all health insurance plans offered by an insurance company affected when an insurance company requests a rate increase request?

No, in general rate increase filings sent to the Insurance Department are reviewed in relation to a specific policy form filing and are not general rate increases for all plans. The claims experience considered by the Insurance Department represents the total claims generated by Connecticut policyholders/certificateholders who are enrolled in the same policy form submitted for rate review.

7. What is the basis for the Insurance Department's authority for rate approvals?

The Insurance Department authority to review rates is defined by Connecticut General Statutes and is limited to review based on the following three criteria: whether the rates are excessive, inadequate, or unfairly discriminatory. There terms are generally understood to mean:

Excessive Rates – are rates that are unreasonably high in relation to the benefits provided and the underlying risks.

Inadequate Rates – are rates that are unreasonably low in relation to the benefits provided and the underlying risks, and continued use of the rates would endanger the solvency of the insurer.

Unfairly Discriminatory Rate – is a rate which is not actuarially sound and is not applied in a consistent manner so that resulting rate is not reasonable in relation to the benefits and underlying risk.

When a health insurer or HMO requests a rate increase, the Department's Actuarial staff reviews many factors, including the submitted data showing the cost of medical care and prescription drugs, the company's past history of rate changes, the financial strength of the company, actual and projected claims, premiums, administrative costs, and profit. The Department approves the request if the carrier can show that the new rate is not excessive, inadequate, or unfairly discriminatory in relation to the benefits provided. If the carrier's data does not fully support the increase, the Department will ask for more information, approve a smaller increase, or reject an increase.

8. Are other factors taken into consideration in making rate increase determinations such as executive compensation?

No, the Insurance Department rate authority is defined by law and is based on an actuarial review of rates based on claims expenses for a particular policy form. There is no authority in place to make rate increase determinations in relation to other factors including executive compensation.

9. Why do health insurance rates increase for policyholders who experienced little or no claims?

Insurance is designed to spread the cost among all individuals who purchase a particular policy. All individuals who buy insurance share in the overall experience of the group so that the cost of claims is spread among all members.

The protection given to consumers under insurance provides an equitable vehicle to ensure that consumers uniformly share in the benefits and risks of the plan regardless of their personal claims experience for that given policy year.

10. What is Connecticut doing to improve the rate review process and make it more transparent?

The Insurance Department posts all health insurance filings on its website and makes them available to the public. Consumers may track the status of upcoming rate reviews from the initial date of submission by the insurance company, to the final actuarial decision by the Department. During the rate review process, consumers may post relevant comments about the specific rate filing that will be reviewed by the Department and their comments are made a part of the filing record.

The Insurance Department encourages policyholders with individual health insurance coverage to sign-up for e-alerts so that they are notified when rate filings are posted; and to receive periodic information posted on insurance related topics. Individual policyholders will also receive prior notification from their insurance company when a proposed rate increase is filed with the Insurance Department.

11. What can consumers and small employers do if they wish to they wish to shop for coverage?

Connecticut has a competitive health insurance market with many companies that sell individual medical insurance coverage and small group health plans. Connecticut consumers and small employers, therefore, have a variety of companies and plans from which they can comparison shop and choose the right plan. The Insurance Department has information on its website showing the companies who market health insurance in Connecticut along with their contact information.

Beginning in 2014, consumers will have a new option for purchasing health insurance when Connecticut will establish a Health Insurance Exchange. The Exchange will offer consumers and small businesses a marketplace in which to shop for various health insurance plans. The Exchange will also offer federally sponsored premium tax credits and cost-sharing reductions to qualified participants.

12. What additional protections are available to Connecticut consumers under Federal Healthcare Reform?

Major changes to health care are occurring at the federal level. National health reform is intended to have a significant impact on how health insurance is structured across the nation including greater accountability on how insurance companies set prices. Important new protections include a requirement that insurers of individual and small group health plans spend at least 80% of premium on direct medical care and efforts to improve the quality of care. Insurers selling to large groups must spend 85% of premiums on medical care and quality improvements

For more information about the federal healthcare reform law, click on the Health Care Reform link on our website at www.ct.gov/cid or call our Consumer Affairs Department at 1-800-203-3447.

13. Where can I submit a new question that wasn't answered here?

Consumers interested in having the Connecticut Insurance Department review an insurance complaint or consumers who have questions about their individual situation, may contact us for assistance:

Connecticut Insurance Department

Consumer Affairs Division

(800) 203-3447 – Toll Free from Outside Hartford

(860) 297-3900 – Direct Line

Email: cid.ca@ct.gov

www.ct.gov/cid